Meaningful Use Workgroup
Draft Transcript
June 1, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody and welcome to the Policy Committee's Meaningful Use Workgroup. This is a Federal Advisory call so there will be opportunity at the end of the call for the public to make comment; a reminder also for the workgroup members to please identify yourselves when speaking.

Let me do a quick roll call: Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Latanya Sweeney? Michael Barr could not make it. James Figge? Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Judy Murphy?

Judy Murphy – Aurora Health Care – Vice President of Applications
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Joe Francis?

Joseph Francis – Department of Veterans Affairs – Associate Director, Health Services Research
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Josh Seidman?

Josh Seidman – ONC
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
I don't think David Bates could make it either. So with that, I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wonderful. Thank you, everyone for this our final call. We might run out of time and we can try to schedule another call, but it seems like that would be pretty hard between now and a few days from now, so let's try to move through this agenda fairly quickly and try to make concise comments. Although we don't have it on the items for discussion, I hope people have looked over the PowerPoint slides that have an update based on our last call. It's an update from the HIT Policy Committee and then our last telephone call, and I've certainly looked at it and this is a lot of the work that George did to try to make sure that we have captured the discussion that we had both with the Policy Committee and on their last call. Are there any changes that people noticed where we haven't captured exactly what we had discussed in those two meetings?

Marty Fattig – Nemaha County Hospital – CEO
When does that report come out? This is Marty.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was yesterday, was it?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, yesterday. Marty, did you not get it? I can send it to you quickly.

Marty Fattig – Nemaha County Hospital – CEO
I did not get that. I received a number of other documents, but I did not –

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay, I'll send it to you right now. Thank you.

Marty Fattig – Nemaha County Hospital – CEO
Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great. Okay, so the first agenda item is to look at, we're trying to consolidate the summary of care and the care plan together, and I think you got something from Christine via Eva Powell, looking at an attempt to bring that together and enumerate some of the elements of that. Christine, did you want to walk us through that? The document's marked "Care Coordination Discussion Document," and it came out yesterday, I believe.

Christine Bechtel – National Partnership for Women & Families – VP
Sure. A small group of us met to talk about how we might evolve the summary and care plan and achieve some parsimony in some of the criteria. So what we've come up with is in the document that we sent around, and this is a document for the care team only, it would go under the bucket of care coordination, so it's distinct from any of the patient and family engagement criteria. So what we did was look at the fields that we already requested in stage one for the EP clinical summary, the after visit summary, and then looked at the fields that we proposed in the RFC for the hospital visit summary as well. And you can actually see, we left it in here just as an FYI, the table, a two column table towards the bottom of the first page and at the top of the second. We looked at what we essentially were already asking for, and therefore what we could use to create the summary and care plan that providers would exchange amongst each other.

What we're suggesting here is that you could actually collapse three pieces into one. The summary care record, the care team member list that we agreed on, and then the care plan notion that we've been talking about, which is essentially the clinical instructions, which is already part of the EP clinical summary and the hospital visit summary, with the addition of some kind of a free text goal field. And you'll see that at the bottom of the table we've got a little ... that would denote the one new item that we're suggesting here. So what we've said is that you basically would combine those fields into one thing and that would constitute the care summary and plan. We're not suggesting how a healthcare provider might configure that, that that's really in their judgment and in their own workflow just like it's done today.

So the second piece, there are two other pieces, but I want to break them so we can talk about each separately. The first is the content, and that's what I've just reviewed. The second is in this discussion the notion of a care team member and how we define that came up, Neil Calman raised it and raised some really important issues. So the group's discussion focused on how we might define that, and you can see what the intent is, what the content might be, and how it might be populated is also in this document. Then the third piece is how this relates to the exchange of this information and how it would be provided and therefore how it would be counted.

So before I go into that piece, Paul, do you want to just start with people's reactions to first the content and then the care team member definition?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sure, that would be a good point. Comments?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I don't have that document you're referring to.

Judy Sparrow – Office of the National Coordinator – Executive Director
Let me send it back to you, Art. I'll do it right now.

Christine Bechtel – National Partnership for Women & Families – VP
Eva sent it around last night and then Judy also included it in the materials for the call today. That might help.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's called "Care Coordination Discussion Document."

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, I didn't get anything from Judy, so she'll send it to me now. Thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I have a couple of comments. One is just a technical, you called out a specific service, AFP, Surescripts, I'm not sure we want to –

Christine Bechtel – National Partnership for Women & Families – VP
No, Paul, because that was actually the piece of the discussion that I was holding because I think it's more complicated. That's the provide thing. I can explain that now if you want, but I was thinking we could do the contents of it and the care team member and then go to that. It's up to you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. The other, I'm not sure why your intent is identifying external member why wouldn't you be interested in the folks in your group taking care of the patient?

Christine Bechtel – National Partnership for Women & Families – VP
Great question. What we said is that if they're internal you're probably sharing the same record system, so you would just be able to look in the same record and see the care team members who are contributing, and that was based on Neil's experience. So what we mean here is not necessarily external to your IPA, but not sharing the same record system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wouldn't you want one place to go find out who this person's PCP or other care team members are?

Neil Calman – Institute for Family Health – President & Cofounder
The clarification was this, in terms of measurement for what we're talking about asking providers to do, we're saying that we want this to be something where there's some communication externally. But in terms of listing who the care team members are, it should be the people who are both internal and external to the organization. But we didn't want it just to be limited to the people internal to the organization. I think that was the intent.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, in fact at least what I was thinking based on our previous discussion, Paul, and going back to your notion of at least listing the primary care provider, is that this criteria is really about care coordination with folks who aren't looking at the same record that you are, so you presumably naturally know who they were. So we were trying to really define care team members who you might need to send a summary to, which is different from people who are sharing the same record who are just looking at the record and don't need to be sent a summary necessarily.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I guess I'm just saying if you're going to use a field called "Care Team Members" you'd like to publish it to everyone who has access to the record, including the patients. And to segregate them or have somebody go find things, it's just sort of like vital signs, you can go over to the Vital Signs tab, but when you're looking at the progress you'd like to see it all in one place, it's that kind of a thing.

Christine Bechtel – National Partnership for Women & Families – VP
How should we change this to reflect that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we should just say "Identify the care team members (internal and external) who treated the patient most often within the last 12 months." It's let's find out who's been actively treating this patient, and as I say you'd publish this in the PHR patient portal as well.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, got it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are there other comments?

Christine Bechtel – National Partnership for Women & Families – VP
So on the content, ... this is not really new stuff, so there should be, at least from the EP clinical summary, standards already in place, because these are the things that we requested in stage one. So that was my reference earlier. So there's not much new here, but we want to make sure we've got everything that we need with the addition of goals, and then there are the ... items that come from the discharge instructions definition in the RFC.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, can I make a small technical comment?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, absolutely.

David Lansky – Pacific Business Group on Health – President & CEO
In the summary note from Christine and Eva it says "diagnostic tests," and the original RFC is the diagnostic test result, and I hope we can keep that concept in here as this gets circulated around.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is that acceptable, Christine?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, we can make that change.

Marty Fattig – Nemaha County Hospital – CEO
A couple of things. I still am a bit confused, I guess, about what a care team member is. Is that a physician? Is that a nurse practitioner? Is that an RN? Is that a respiratory therapist? What is it?

Christine Bechtel – National Partnership for Women & Families – VP
Marty, that's a good question. I'm thinking of it in today's context and whether it matters that if the patient is saying "I see a physical therapist down the street," or, "I see a nurse practitioner led practice." It's just really supposed to be the clinician that treats the patient most centrally, aside from the physician you're already seeing. So we didn't feel the need to define the type of provider.

Eva Powell – National Partnership for Women & Families – Director IT
Ideally, the definition of care team member would be anyone who has a role in carrying out the care plan. So by virtue of that fact, it's really not possible to define specifically in a regulation who should be in there.

Marty Fattig – Nemaha County Hospital – CEO
It just makes it extremely difficult to carry out, and also when an audit comes in, did we include them all or not.

Eva Powell – National Partnership for Women & Families – Director IT
I don't think we're asking for all. We're just asking for the primary, at least one was the – by the way, we didn't actually change the intent, we just tried to articulate it, that we'd already agreed on. So this was back to the discussion that we had where we hope there's at least one and if you're a specialist we hope that that's sort of a primary person treating the patient.

Christine Bechtel – National Partnership for Women & Families – VP
The primary care provider would be the expected entry and then allow the providers and the patients working together to identify other members of the care team, and with the notion that as ... begins to be populated and used that it will be of value, such that this will then take care of itself. And we had a good

discussion, and Charlene raised the point that if these, and we'll get to the how these things get provided and exchanged in a minute, but if these things are in fact provided you could actually populate them automatically from either referral center received, which you'd have to track under stage one anyway, or receiving care summaries from others, that those could be automatically populating the care team list. Then the only manual piece of this might be if the patient says, well, I want to add a member and here's who that is, and you basically treat it almost like a piece of demographic information. I think the list will grow over time as people are using more and more of the functionalities in meaningful use, but all we're asking for is make sure you've got at least one other person in there at this point.

Marty Fattig – Nemaha County Hospital – CEO
I think this is important to get all the providers recognized, and it would appear to me that either in the primary care provider's record or in the HIE record that this would be the place to have all this information.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What we continuously hear is the more precise we are with our definitions, one, the fewer questions, and obviously it's easier to implement. Should we go ahead and explicitly say that we're asking for the PCP where that exists and essentially making that the required field and other entries as optional?

Christine Bechtel – National Partnership for Women & Families – VP
I struggled with that, and Neil, you may want to weigh in, because number one, if you are the PCP who do you put in there?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You'd put yourself.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I guess. But I think the point is to facilitate care coordination with other people not just you. So it's fine to go in there, but I think we're also looking for anybody else who primarily treats the patient. I don't know that we would say you can't do that, because if you're really the one person who the patient sees all year long and they're not seeing other specialists, then that's fine. But we also want to make sure that you're asking the patient as a primary care provider, you're saying, okay, is there anybody else on your care team, and you put those names in there.

M
I think the purpose here, and again, part of the problem is that you don't want the inability to be precise and measure it to keep people from doing what we're trying to call out. So I don't know where to end up with in terms of what our recommendation is, but it's clear that the intent here is both other providers and patients need to know who the main players are. From my perspective I'd like to be able to have the patient have in their visit summary or in information that's being transmitted to another provider who the specialists are that they're seeing on a regular basis for any chronic ailments that they have and who the people in our practice are, who's the diabetic educator that they're seeing or whatever. I think the different practices are going to develop this in different ways, and that's okay. The problem I think is in figuring out what are we recommending as a requirement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, and I guess that's why I proposed ..., and we've heard this at least from the specialty panel, is to say a minimum of PCP where one exists. So we're going to start having this field in the EHR because we don't have this right now, and it would at least have the PCP and then people will start populating it as they're able, and of course this is going to depend on the provider ID, etc. So it has to accept text as well, but for the folks where you already have a relationship, you've already assigned an ID, you'd want that coded.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Paul, we discussed a little bit of this yesterday and again I think David had weighed in on this, is if it's a byproduct of the provider index for some of the HIE focuses for exchange, it's not a natural thing that you're going to be able to get the transaction ... that incoming provider into your system. But what's probably more important as we start to standardize some of these different elements of this, because again each of us consider those roles in a different way, so that if you really want to exchange some in the future there's a glide path to what that exchange might look like as we move out. So I'm fine with the minimum starting, but this should be thought through a little bit more so that some of that infrastructure can be ready for stage three.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I agree, and I think what we were intending to do in having this intent ... would give Allen and Josh enough to go on in terms of being able to write the narrative letter, where we're signaling here's what we're trying to do and here's what we're asking for. I think there's probably enough agreement if we focus on Neil's concept of who the main players are. And we talk about in here that we at least need a name and we want to ask the Standards Committee to recommend some standardized contact information fields and methods, then I think there's enough to get going for stage two and then get it even more structured for stage three. It may be that if everybody's in general agreement with the conversation that we've just had on care team member we could help Josh and Allen, if they need it, with the language that would describe it in the narrative.

David Lansky – Pacific Business Group on Health – President & CEO
My only add was to say that I think not only the Standards Committee but the IE Workgroup should be asked to address it, because they've spent so much time on provider directories ... an important use case for those directories.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Judy Murphy – Aurora Health Care – Vice President of Applications
I just have an additional question for Christine. I understand the three components, but is there any further definition of the plan of care, like what the components are for the plan of care? Because it looks like the summary is pretty itemized out and the care team members are pretty itemized out, so the plan of care doesn't have any definitions yet.

Christine Bechtel – National Partnership for Women & Families – VP
The plan of care is towards the bottom of the table. It's really just adding to the summary components, the goals, the goal fields where you can describe the goals that the patient and provider agree upon, that in stage two we're not trying to be overly prescriptive. But we're saying that on the whole if there is a summary of what's going on for the patient and goals about that care, that that will constitute a "care plan" in stage two.

W
I think that's more like we did with the note piece, we ... flexible in terms of how, because there are so many variations of that and I think that it would be much less prescriptive.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Judy Murphy – Aurora Health Care – Vice President of Applications
Okay, maybe I could ask, it does say, for example, "instructions in notes field." I'm not actually sure what that means.

Christine Bechtel – National Partnership for Women & Families – VP

It's what I had said. There are two fields in the summary document already – I'm sorry, there's one of them that's in there already which is called "clinical instructions" and that is basically a notes field. And then what we're suggesting is that there's a field added for goals that is basically free text, unstructured for now, because we don't want to push too far in stage two. For stage three we can think about whether it's needed to do more structured work, but for our purposes it's really using the summary of the picture of care and condition right now plus clinical instructions, which is already in there, and then goals.

Judy Murphy – Aurora Health Care – Vice President of Applications
Plus goals, got it.

Christine Bechtel – National Partnership for Women & Families – VP
We tried to be just very flexible, and the provider is the one that figures out how you configure it, how you describe goals, etc., just like happens on paper today.

David Lansky – Pacific Business Group on Health – President & CEO
On the subject of content I'd like to make a couple of suggestions anyway for discussion. Part of what we've all wanted to do, and we just came up, was to make sure we anticipate stage three and where we can send a signal to vendors that here is the directional requirements for stage three. So whatever coding and engineering you're doing now anticipates that, it seems to me that this is a place where if we send out this table of contents to vendors and they start coding against it, they may box themselves in from some flexibility we want them to have for stage three. And because in stage three and even stage two we're recommending some additions to the content and functionality in the criteria, the four that came to mind that we might want to add to the table as configurable but not required as something is the patient's e-mail address and contact information, the family health history field. Even though they're not standardized yet we're going to be talking about them for stage three, something about the preferred communications medium so the receiving provider knows what form the patient wants to receive supplemental and continuing communications in, and then some kind of fields for the patient supplied data that we're proposing to request. How to do all that may be daunting, but I think we should at least have the Standards Committee begin to look at it.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, that makes sense, David. What we would do is, the structure that you see here is already the structure that exists from stage one, but we could communicate that for stage three it is our intent to add patient's e-mail address, family health history, preferred communications medium, and other kinds of patient reported data.

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. Yes, that's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So if we look at what this does, say, to our matrix, our PowerPoint slides, right now we have former menu summary of care record. That becomes summary of care record the new version, and then there's a new one for care team members, a new one for longitudinal care plan, which was merged, so really it's starting to look very similar to what we have. We're just going to say this is one objective and it includes care team members, and other than that we'd like to be a little more specific about what we're talking about, which we wanted to do even if we left those objectives. One difference I see is the idea of what gets shared, whether the metric is whether you collect the stuff, or the metric is whether you share it. So right now the important thing about the summary of care record is that you share it with the next person. The important thing about the care team members right now, in our version as of two days ago, is that you have it in your record. It's not so much that you share it with the next person. So we have to work out what the metric is. Is it the sharing, or is it the having it?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that's a perfect segue to where we needed to go next, which is the providing. I think that what we're suggesting here is that the metric is actually the sharing, which is going to require you to collect it. If you have to share it you've got to have something to share, so that requires you to collect it. When we stepped back and thought about this, I did some outreach to Arien Malec at ONC about the Direct Project and how all of that works and, as you all know, Direct is a set of standards, services, and policies that facilitates what is basically secure messaging between providers. Arien described it as a secure G-mail account and he said that you can integrate it with an EHR, but one is not required. All you need is an Internet connection and you can establish a Direct inbox. And it doesn't have to be through Direct, it could be through any comparable service. As you guys know, AFP and Surescripts have a similar service, there are a couple of these who are out there, and you can either establish a Direct inbox for free, or you can, it looks like, buy an upgraded version that would cost a max of about $15 per doc per month.

So when we looked at this notion of how do you exchange this, and we remembered that, Paul and George, there were some earlier references to ... HIE preamble, one of the things that we suggested doing was letting folks know they could exchange through an HIE or they could exchange through Direct or some other means, some other comparable service. So when we started to think about how could you count the transmissions, what we arrived at is that your denominator would essentially be the number of visits in a year for EPs or the number of admissions on the hospital side, which they have to count anyway, and then that your numerator is the number of, this is actually coming from the other document, so the number of transmissions sent and received, which I think makes it easier to meet the goal. So if you count the number of care summaries you've sent and that you've received, I'm going to assume that if you've received it electronically you have the capability to send it. So it makes it easier for providers to hit a 10% threshold if you count both sent and received.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can I ask a question about your EP list? At the bottom you have condition upon discharge, did you intend to have that and activity and diet and pending tests? They seem to apply to the hospital side.

Christine Bechtel – National Partnership for Women & Families – VP
It's from the RFC, from the –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... discharge summary.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, for discharge summaries, right. So that would be for the hospital side.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we wouldn't want to put that in the EP clinical summary, would we?

W
Did we take –

Christine Bechtel – National Partnership for Women & Families – VP
We did take it –

W
....

W
Well, those are key components of the plan. The question before was about what is the plan, and the plan is constituted by condition upon discharge or for the eligible provider you get the general condition.
....

Christine Bechtel – National Partnership for Women & Families – VP

I think those are in here, on the clinical summary anyway, in terms of ...scheduled tests, things like that.

W
Yes –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Scheduled tests –

W
... activity ... are not specific in there. Anyway, we can work on that and tighten it up some, but the point is to have the key components of the plan because that's always a question is what is the plan, we don't know what that is. As Christine said, we want to be as flexible as possible, but here ..., and those have already been defined and something else that was already in the RFC.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I think it's fine if we want to just have those on the EH visit summary, there's some probably articulation on the EP side if we would prefer that. But for our discussion now, since I know we're tight on time, I think that's fine to just have those on the EH side.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, that would be great. Then it sounded like in your summary just before this you were talking about 10% instead of 20%, which makes more sense as well.

Christine Bechtel – National Partnership for Women & Families – VP
There are two different things. This is to George's question. What you see in this document is 20% of patients have a care plan recorded or updated. But what I just described actually has nothing to do with that. We have to decide what approach we want to take, which is George's question, do you want to measure whether you have one recorded and updated, or do you want to measure its transmission? If what we're talking about here is under the improved care coordination, I think we might think about measuring its transmission in some ways, or I don't know, maybe it's both. That's the open question that we didn't quite get around to talking about. So what I just described is actually a transmission measure, and not just from the document that we sent around Friday ....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This is Charlene. I think as we try and measure the different elements of the exchange, two things. One, I'm not sure to what extent all these elements are standardized, so that's something, I don't know, Christine, if you've done that cross-matched with –

Christine Bechtel – National Partnership for Women & Families – VP
Yes, because –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
... interoperability.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, because they come from the EP clinical summary, which was in stage one, so they are standardized.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But I also think, again, in terms of is the field populated or not populated, again, it will be to some extent a challenge to be able to – that's just going to be one more level of measurement. It's not that it can't be done, but it's that it's going to be pretty challenging to ....

Christine Bechtel – National Partnership for Women & Families – VP
I'm not actually suggesting that we measure all the field populations. I don't know how that's done under stage one. But since 98% of what is described in terms of the content of the care plan comes from stage

one on the EP side, I assumed we would take the same approach on both the EP and the EH side in this case. So what I'm describing in terms of George's question, the question is, do you want to measure 20% of all patients have a summary and a care plan recorded or updated. Or do you want to measure that 10% of all discharges have the record or referrals on the EP side, have the record transmitted to another provider where the numerator is the number of transmissions sent and received, and/or received, I guess, and the denominator is the total number of either visits or admissions. Okay, let me simplify the construct. Do you want to measure that the ... exists, or do you want to measure that it's sent?

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that we need to take steps. The fact that we're getting a clinical summary and a plan together is in the formative stages, so I think that would be a good first step –

Christine Bechtel – National Partnership for Women & Families – VP
I agree with that, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... and a big first step.

Christine Bechtel – National Partnership for Women & Families – VP
I agree with that, but remember that we've removed the HIE, the information exchange criteria because it was hinged to this. So it's hard for me to imagine not also having a transmission metric in here. Otherwise, we have no data exchange criteria in meaningful use at all in stage two, which is supposed to be –

W
... from ....

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What do other people think?

Neil Calman – Institute for Family Health – President & Cofounder
I think that it would have to have some sort of a caveat, but I think that we should require exchange in a small number of transactions. But again it depends upon the people on the other end being able to receive the information. I think we need to deal with that also, like there may be places where people just aren't able to receive this.

Christine Bechtel – National Partnership for Women & Families – VP
And, Neil, just as a reminder for the group, we actually had language that had an exclusion for lack of electronic recipients and if that was the case then they must send it on paper through however they do that now, so that's already part of the assumption. And so what we're saying is that 10% of discharges or 10% of referrals for the EP actually have the care summary and plan sent to another provider unless the exclusion of, say there's absolutely nobody in my community who can receive it, which is the exact logic behind us putting something about direct or a comparable service in there. Because the more people you get on direct, which is just like e-mail, the more exchange you're going to have happen and it's a very low barrier of entry for direct, unlike in HIE. So it seems that the more we encourage people getting a secure e-mail address, the more we can facilitate basic exchange and the fewer exclusions that we would actually see, but that option would still be there.

M
Yes.

Deven McGraw – Center for Democracy & Technology – Director
I think that makes sense. Having an exclusion that applies when it's just not possible and in that case you have to use paper I think is the way to deal with this. And it's a fairly low threshold for starters.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How do you tell whether your clinical trade partner has or doesn't have this capability?

Christine Bechtel – National Partnership for Women & Families – VP
Well, in stage three we hope there will be a directory. But I asked that question of Arien Malec and he essentially said, look, we assume that it is just like how things work today, which is you figure out how to get the fax number of the other provider. You often know the providers in your community, and so you're really asking folks, hey, do you have a direct e-mail address. So it's just like how we do it on paper today.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so if we want to have this as two separate requirements and discuss it in front of the Policy Committee and we can see, we'll probably have a discussion about this, how do people feel about offering both of these criteria?

M
Offering –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Basically stating these as two separate criteria and discussing that at the Policy Committee.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Can you sum up again?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There are two requirements. One is that 20% have a summary and care plan, and we've defined this new consolidated summary and care plan with the elements below, and then that 10% have transmitted or received, have created some transmission or reception of this information electronically with a clinical trading partner. We'll probably have a discussion similar to this with the Policy Committee and they can decide whether they want one or both.

Deven McGraw – Center for Democracy & Technology – Director
I say we propose both.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, that's what I'm saying, we propose both. But they'll probably, we'll have this discussion and then we'll have to make a decision on whether we take the first big step or take both steps.

Neil Calman – Institute for Family Health – President & Cofounder
Is it 10% of the 20% that you're saying there?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. It's 20% for having it in your record and 10% is the number – so the denominator for the 10%, Christine, is?

Christine Bechtel – National Partnership for Women & Families – VP
The denominator for the 10% on the – oh, I'm sorry. No, the denominator on the hospital side would be the number of admissions. The denominator on the EP side would be the number of unique patients

seen, actually, I'm sorry, who have a care team member recorded. It's not a huge population, you've got to do it for 10% of all patients, it's where the care team member recorded –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's external?

Christine Bechtel – National Partnership for Women & Families – VP
Well, how we've just defined it. So that wouldn't be consistent with probably how we just defined it, but I think it's workable actually both ways, because it's only a 10% number.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I guess if it's internal then the "transmission" is the fact that it exists.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, but I think, again, what we were trying to do with the care team member definition is specify that it's not people sharing the same record system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, but I –

Christine Bechtel – National Partnership for Women & Families – VP
Right? So a transmission would not count as I just looked it up in the EHR that you and I both shared. So if you're on a different record system, even if you're internal to my organization, so to speak, then maybe a multi-specialty practice, then that transmission via Direct or HIE or whatever the mechanism is, would count.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can we take this off line then and just tighten up that definition so that we have something to present?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And if I could go back to the whole AFP, Surescripts, could we not specify a –

Christine Bechtel – National Partnership for Women & Families – VP
Yes. But I still think we need to say it could be HIE or other service –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fine. I don't know that we're in the business of endorsing anything.

Christine Bechtel – National Partnership for Women & Families – VP
No, I know. This is just our internal document. I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So we'll tighten up that definition and we'll present it to the Policy Committee and they can accept one or both of these. Okay, well let me move on.

M
Paul, we shouldn't do it now, but point out another possible outcome is that some parts of it go under one criterion and other parts under the other. The summary has to be transmitted but the care team has to be collected. I'm just saying that the Policy Committee, that's an option they can select.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct, okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, when you think about the summary care plan there's a lot of development because that concept isn't there but to put in a shared goal is a whole different scope. So there's a scope difference ... talking about too.

Christine Bechtel – National Partnership for Women & Families – VP
Just to reiterate, Charlene, we didn't do anything new except the goal, and it's just the development –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm okay with that. I'm just saying those words, as you talk about, there's a lot of, and Judy can probably attest to this, the concept of care plan is pretty advanced in the industry.

Christine Bechtel – National Partnership for Women & Families – VP
Right, but what we're doing is really creating this amalgamation of the summary and the plan so that we get people what we need and we don't get hung up on whether it exists or not. We're using what we've already identified in stage two and we're adding one small free text field for goals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So probably even as we present it to the full Policy Committee, having those two sentences of what we mean by "care plan" can be helpful, because certainly in nursing there's a very specific definition. So we just want to explain to everyone what we're talking about. It's sort of the beginning, a placeholder that we'll flesh out more in stage three.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Documenting shared goals is a whole different process than creating a whole care plan, so it's important, I think, to make that distinction.

Christine Bechtel – National Partnership for Women & Families – VP
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next one, now we've got to watch our time here. Do you think before we talk about adding things can we go to the specialty, our May 13th hearing, and talk about any follow up with the specialty panel and the experience panel where we ran into certification and vendor issues? Let's go to the specialty panel follow up. We heard a lot from the specialists, what are the action plans that would impact stage two recommendations?

Christine Bechtel – National Partnership for Women & Families – VP
Paul, what do you mean by action plans?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What recommendations did we hear that we would incorporate into our stage two recommendations? A lot of it had to do with the optionality or specialty specific matters, and in our last call David Lansky talked about could we implement that optionality in the quality measures. In fact, he was saying, and David correct me where I'm wrong or chime in, they're very likely for the Quality Measures Workgroup to have specialty specific measures, and that's where specialists can choose the measures that are relevant to them. The question is, are there any criteria we have for functionality that is completely irrelevant to a specialist and how would we deal with that?

Christine Bechtel – National Partnership for Women & Families – VP
There are, off the top of my head, I think reminders to patients for preventive and follow up that doesn't always apply. For some specialties it does and some it doesn't. Some of them are going to be able to provide access to the patient's health information electronically. The public health stuff we talked about last time does have exceptions. How you define a clinical summary probably doesn't apply universally. I think they can give patients a summary if there's a visit, but number one, some specialties don't see patients directly, and number two, the way we've defined that summary is probably not appropriate for all

specialties because I think there are things like immunizations, referrals, and preferred language, I don't know that they would collect those things. I like the idea of a core and a menu approach for specialists but not all of the functions are going to be quality measures, so I'm not sure how to approach that. I know we talked about this last time so I wasn't sure if ONC went back and did some work based on the hearing to identify those particular functions, but off the top of my head that's the best I can come up with.

Marty Fattig – Nemaha County Hospital – CEO
Paul, I am of the opinion that we need to see what, because many of these specialists, as well as primary care providers, are currently installing software to meet meaningful use stage one. I think once they get that system in place we'll have a better understanding about where the gaps are and information that needs to be collected to complete a record that would be of value coming from a specialist's office.

Christine Bechtel – National Partnership for Women & Families – VP
I guess in my view I think there's a couple of other factors. One is, first, you have to decide if they see patients or if they don't. And the second piece is, if they don't buy the EHR they shouldn't be eligible for the money, period, I think. We heard from the pathologists who don't make the investment, in fact, they use a lot of information systems and the hospital provides an EHR. But if they don't make that investment, I'm not sure why they would be eligible in the first place. I think there's almost a check-off list, did you buy the EHR? Okay, keep going. Do you see patients or not? And then if you do, here's the track for you and there are some exceptions to the functions but you also have to add these quality measures. Do you see what I'm saying?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. I thought they said they are eligible because of not having the 90% in the hospital. And because they're eligible it was almost as if they were not so much looking for an incentive but they wanted to not be liable for the penalties.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, which certainly makes a lot of sense. Josh, I don't know if you can advise if that was an administrative decision or if it's a function of the law. Because there's something in my head that says that that was actually an administrative interpretation of the ... provision because I think, yes, you shouldn't be subject to the penalty if you didn't buy the system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is anyone from CMS on the phone? I think there is something in the statute, I'm not sure exactly, I know it's something that CMS has been talking about.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, so maybe, Paul, just in the interest of time we take that question, Josh can help us understand that question. But in terms of whether you see patients or you don't, are there two different pathways for meaningful use, knowing that in the end you can't make it easier for specialists and harder for primary care. So you either have to have more menu options or more quality measures that they're accountable for to get the balance right, but should there be some exceptions to the functions similar to the quality measures for certain specialists?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're referring this to an administrative decision on their eligibility, and the main point of the eligibility was if they're eligible then they're also liable for the penalties.

Christine Bechtel – National Partnership for Women & Families – VP
Right. So what I'm saying is a level below that, so let's assume that they're eligible, there are still some specialties that see patients and some that don't see patients, and for me that seems to be a key distinction, maybe I don't understand it. But the fundamental question is, should there be a specialty track for those who are in fact eligible for meaningful use that have a core set of functions. But that also has a longer list of functions and quality measures that they jointly need to choose from to arrive at some

certain number so that the meaningful use for them looks a little bit different than it does for primary care, but it's more appropriate to their specialty.

Josh Seidman – ONC
I'd just say that we definitely understand the rationale behind that. I think that we get a little concerned about how you would group specialties and whether then you would actually have not just one or the other but multiple approaches, and that could get very confusing.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, this is kind of the case of the radiologists, because now by definition they're included as an EP of ... language and the law. So they'd analyze the meaningful use criteria, and I don't have that document with me, but again, 12 of those elements pertain but again they can't move forward because they have to buy a complete EHR. So to support the specialties, my preference clearly would be well we can use a measure, but it seems like if we really want to support the specialties we've got to provide some, rather than a whole new menu set, just provide the capability for them to say this does not pertain. It doesn't seem to make sense to come up with a whole different set of stuff, except just allow them to use their judgment and say that it doesn't pertain in some way.

Christine Bechtel – National Partnership for Women & Families – VP
I guess –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And again they're audited to that too. There will be an audit process.

Christine Bechtel – National Partnership for Women & Families – VP
Charlene, I agree with you. I'm just also thinking, I don't think it's fair to make this harder for primary care than for specialists, particularly in this payment environment that does reward specialty over primary care still.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't disagree.

Christine Bechtel – National Partnership for Women & Families – VP
But one way to do that, which I think is part of what David was saying, would say, okay, you can exempt yourself from "x" number of requirements, but you have to choose a higher number of quality measures to perform on, I guess. There's no performance, actually, it's just reporting. So they just have to report a larger number of quality measures.

Neil Calman – Institute for Family Health – President & Cofounder
I think it's going to be very helpful for this discussion to group the specialties. There are office-based cognitive specialties where there's going to be a lot of convergence in terms of the use of the electronic health record, so a cardiologist is going to use the electronic health record very similarly to the way I as a primary care physician is going to use it. Then there are groups of specialists whose practices are so different, both in terms of technology and other things and in terms of their focus, so I'm thinking about ophthalmology and podiatry and things like that where you're dealing with specialists that have very, very different practices. Then you have the radiology, pathology, rehabilitation, the things that are just so different. We keep talking about specialists, and I think it's like talking about doctors. We're just not going to be able to come up with one solution that deals with all of these groups. Then there's a lot of practice cross-over.

So I'm going to go back to something that I said very early on, we should decide what's important, we should not try to fit these pegs in a hole that we've created that's mostly thinking about primary care and cognitive office-based patient specialties, and what we should do is think instead what do we need these folks to do. And maybe there needs to be different criteria for their participation completely, like what do we really need for somebody who's doing rehabilitation medicine. It's a very different set of things. And I think we're going to pull people down lots of side roads that are not going to benefit the public if we try to

fit everybody into this mold that we've created that's different, that's around primary care office-based specialties.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One ... that Christine seems to be suggesting is the people who see versus the people who don't see patients directly, so that covers the radiologists, the pathologists.

Neil Calman – Institute for Family Health – President & Cofounder
Radiologists often see patients. And some radiologists see every patient, depending upon the type of radiology they practice. That's my point. It's like we're trying to make these definitions where they're not going to fit a lot of people in a lot of practices. It's going to make a lot of people angry and a lot of people are going to waste a lot of money in resources and they're not going to do what we need them to do, which is to take it to the next level. So for radiology, for example, I think to qualify people should have digital radiology and have a pack system that's accessible to providers in the community. That's what's important to me, is that whoever the radiology group is has a system that I can access so that I can see the images that I'm sending them for. And I can care less about the number of recalls and other things that they're doing, that's my job. They recall people for abnormal tests and stuff like that, and we'll have quality criteria that are specific to that specialty. But I think what we need to do is figure out what do we need from each of these specialists to move to the next step of improved patient care.

David Lansky – Pacific Business Group on Health – President & CEO
I agree with Neil's main point. I was going back to the notes from that last hearing that Paul mentioned, and it does seem like we got a different lens through the eyes of each specialty we heard from. I know the quality measures is a relatively easy place to tailor the requirements to the specialty and the type of care they provide, and we have never really grappled with the implications for the functional criteria, essentially there are two big paths. One is, you said earlier, Paul, should we re-review all the stage two proposed criteria through the eyes of the specialists and say are some of these appropriate to waive or exempt people from, given the nature, as Christine said, of certain specialties.

The second is, are there some pathways for some specialists or groups of specialists where there is some common functional requirements for that type of specialty, I think where Neil's going, that deserve visibility in the meaningful use program, but don't really apply to everybody, especially all primary care. So, for example, I think care coordination came up as a place where specialists are most, there's some critical functionality around care coordination that we want to emphasize for specialists especially, and there were a couple of suggestions during the hearing of things we can do to beef that up. Someone suggested asking the patient if a loop had been closed during a care transition. Someone suggested measuring the timing of document transfer between key physicians in that handoff, so the data information's there in a timely way, whether it's a referral, report back or whatever. The radiologists talked about getting prior imaging results available to the ordering physician as an enhancement to CPOE analogous to the medication history retrieval, and then there's a lot of discussion about appropriateness information being available to help guide ordering decisions for high cost services by specialists.

Those are all valid things we can think about, but they don't apply to everybody. And ONC may say it's too cumbersome to think about layering the functional criteria for groups of specialists with common requirements, but I think that would be responsive to what we heard from the hearing.

Christine Bechtel – National Partnership for Women & Families – VP
Yes –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Some of the things –

Christine Bechtel – National Partnership for Women & Families – VP
Go ahead, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that that's a good direction. Building on what Neil was saying, so not all practices, not all specialties are the same. But we want to make sure that most specialties, if not all, participate in this electronic capture and exchange of health information. So from the radiologists we do want access, not only to the reports electronically, but in many cases the images. The same for pathology, we want the report. So how do we design a system that would encourage it? On the one hand maybe the market would address the needs of getting information electronically back to us from radiology and pathology, for example. I don't know. A lot of the things that David mentioned could be measured by quality measures that apply specifically to specialists. So all specialists might have a core of timing and response back to the referring physician, for example, checking some of the appropriateness, having the patients answer ... the loop closed between specialty care and primary care. You can see how specialists could be measured on things that are important to the referring physicians if the requirements we have for the core functionality of the EHR are not things that, as there may be very few of that core functionality that could be waived in specialists' case.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I agree. And I think this is a deeper conversation and it probably requires some pre-work. We were given a number of documents in the hearing that identified some of those functions that were not necessarily universally applicable. If we were able to pull those out and figure out what they get replaced with, whether it's a quality measure or something else, I think that would be good. That what we would look at is not, coming back to something Josh said, I don't think we're asking CMS to identify all the specialties and put them into an eligible track. I think we're asking the specialists to self-identify what track do they want to be on. And to have the specialist track be heavily about care coordination makes a lot of sense, and having them share the summary of care and plan that we just talked about would make a lot of sense. And to send a copy of that to the patient at the same time would be even better so that we're at least starting to get, even when I go see an ophthalmologist that ... care team member and they're saying, okay, I'm going to send this report, who do you want me to send it to, okay, great, and then we keep going.

But that being said, I think that's the right approach, but I think we need some pre-work to figure out what functions are where and get really specific. And I don't think that that's possible, it sounds like, on our schedule before June, but maybe we can follow up our broad meaningful use recommendations with a second set of recommendations around how to deal with specialties at the next Policy Committee meeting.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The intent of the law between adoption and HIE is to, I agree with what you just said, share in the information so everyone has access to this common longitudinal record, number one. Number two, as Christine just said, and then coordinate the care plan; and then number three, use this infrastructure to improve quality, and that I think was the intent of the law. I like Christine's way of putting it that they have tracks that people put themselves in, because remember at our hearing some specialties said well, this doesn't make sense for us. It's our job to figure out how to make it make sense so they can get incentives. Other specialties came in and said this doesn't make sense for us and we understand that but just make sure we don't get penalized later on. That kind of thing is going to have to be up to CMS to figure out how to navigate that. Our job, I think, as Christine said, is to say, here's the tracks that are available, that that would make sense in broad terms. But how we do it, like I don't know if waiting for another meeting, of course the mechanism for us to do that, given that the meeting is next week, is tough.

Christine Bechtel – National Partnership for Women & Families – VP
Right. People have been asking for this for, what, a year and a half, so I think we can't in a two hour phone call try to knock this out. It was great when we had a hearing and I think we all learned a lot. But I don't see it happening. If CMS and ONC have our first tranche of recommendations for four weeks and they can start working on reg writing, Josh, I don't know what you think of this, but to get a second set that's really about specialists you could still be moving the fuller recommendations along I think as a bonus. Because there's no way that we're going to be able to resolve and create a specialty track on this phone call.

Josh Seidman – ONC
I think that probably you're right. I think if the Policy Committee feels strongly about this I think that it is important to come up with some pretty specific recommendations, because I know that in conversations with CMS that it's something that both CMS and ONC are very concerned about, very aware of. We are trying to figure out pathways, but it's very challenging once you actually try to create the different pathways. I think if the Meaningful Use Workgroup and the Policy Committee can come up with some very specific recommendations, which I agree would take some time, separately from the June 8th meeting, I think that that would be a more appropriate way to try to handle it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think ... track the way I might do it is you take stage two and you identify those objectives that are the, I don't want to call it core set, because we use that word another way, but it's the set that really represents the sharing of the health records, the sharing of the care plan, and the quality improvement. These are the functional measures that are essential to everyone, and just identify those to CMS, which could then use them in different ways. And kind of what Christine just described, identify that set of objectives, which would not be the full set, so like privacy is still going to be in that set because you have to maintain your privacy, and the sharing of the referral document, a lot of it actually goes into that group, and that's what really everyone can do. The minimum set that everyone has to do, then you say well then the PCP shouldn't be penalized by having more objectives than everybody else, so therefore you have to add some more of these to specialty. I'm not sure if that's true or not. But there is some core set that everyone has to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... complement, which is I think the majority, and the vast majority would apply to all. So perhaps what we do is go back and look for specific exclusions and try to precisely define what kind of specialties would qualify for that exclusion and at the same time work on the important cross-cutting measures for specialists in the quality measure area, such as the timely turnaround and that kind of thing. David Lansky, when is your group going to be reporting on the quality measures, do you think?

David Lansky – Pacific Business Group on Health – President & CEO
Well, we have a report now. I don't think we'll have a detailed layering of the specialties for a while. Part of it is we have all the new measures are in this long term development cycle.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So for stage two when do those recommendations come out?

David Lansky – Pacific Business Group on Health – President & CEO
We haven't even really talked about a specific schedule for building the menus. Right now we're just talking about the structure of the menu, not the composition of it. I don't know, Josh may have a better feeling for the timeline.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Josh, when are you counting on those, or whoever's on for CMS, when are you counting on those as you plan to compose the NPRM?

Josh Seidman – ONC
We're going to begin the writing process very soon, after the June 8th meeting. I think that if there are specific outstanding issues that need to be addressed, it's probably better to get the bulk of the approved recommendations to HHS sooner and then other things can ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You just want to –

Christine Bechtel – National Partnership for Women & Families – VP
Paul, it's Christine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... dovetail with the schedule and if we decide what we're going to work on is the exclusions for the core functionality linked to the specialty quality measures across specialty measures, that might make a sensible set of follow up recommendations. But we have to be on time for that to appropriately influence the rule writing process.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I think that's the right approach. I just would add one other issue that I think we need to, I know I need to understand more and would like to be able to do something about if possible, and that is this notion that specialists have to buy a whole EHR and it has a ton of functions that they won't use. I just think that's something we should at least understand and see if there's anything we should or shouldn't do about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Well, the nice thing is by using the exclusion approach that also excludes them from the certification criteria that addresses that particular functionality.

Neil Calman – Institute for Family Health – President & Cofounder
I think we heard previously that there's some aspect of unreality to that in that the EHRs are not necessarily being developed to do that, that you buy an EHR it's going to have that functionality. But I just wanted to reframe the specialty thing again. I don't think we should be talking about it in terms of what we're excluding them from, nor should we be talking about it like we can't make it easier for them than we're making it for primary care. I think we have to look at it in the other dimension. It's what do we need from them that they're currently not doing that will make care better for our patients. It's a positive attribute that we're looking to enhance through an incentive program, so, for example, we could potentially develop for specialists a structured way of reporting back to primary care providers their findings.

This is something we've been working on internally within our own specialty network, which is unbelievably helpful. Instead of getting these huge nondescript messages back, to be able to say here's a summary of the history, here's a summary of the findings, here's our recommendations, here's what the patient's been told, here's the follow up plan, and be able to develop some sort of structured format that would actually improve the delivery system. I think we need to think about that kind of stuff in a very forward-thinking way rather than the exclusion piece. I think the exclusion piece is important, but the substitution should be something we think of going forward and we probably need a group to work on that. And I'm not volunteering to chair it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil, maybe one way of accommodating that, I think that was a very helpful comment, one way of accommodating that is to build the specialist structure template in our summary of care document that we described and those sections will be very useful and more applicable to specialists than primary care. But instead of trying to come up with a separate track, that's what we're trying to avoid, exclusion can be one, and I think that would be used in very small numbers, really. The other is to specify an appropriate summary of care record for specialists that address what you just said. I'm trying to find ways to work it into the existing structure.

Neil Calman – Institute for Family Health – President & Cofounder
I think that would be useful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then of course the quality measure can go measure the same ... on what's the percent of the time that you return that, one, in a timely way, and two, in a structured way.

Neil Calman – Institute for Family Health – President & Cofounder
I think that would be extremely useful and I think it would really advance care for our patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are we having some consensus around this? So let me try to summarize. We would go forward with our draft recommendations for stage two. The caveat from a specialty point of view is that we would come back and do additional work on identifying the very small number of core functional objectives that may not apply to specialists. In return we also will identify either cross-cutting specialist specific documents or templates such as clinical summaries, and quality measures that would emphasize the areas that pertain to care coordination between specialists and primary care providers. Is that a fair approach?

Neil Calman – Institute for Family Health – President & Cofounder
That's good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How does that satisfy others?

Deven McGraw – Center for Democracy & Technology – Director
It sounds good, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, thank you. Okay, so let's move on. I think that's a good way of doing it. We'll also have to deal with imaging, which is certainly something we hear about, and heard about at the panel, and probably can handle in this way, and can apply quality measures to that as well as specific functional requirements.

The next topic, and, Neil, this is something you had championed, was the amount of information we got, the amount of discussion we got about the certification process or maybe the certification thresholds, and the ability of vendors to support the implementation –

Neil Calman – Institute for Family Health – President & Cofounder
That's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... the timelines for meaningful use.

Neil Calman – Institute for Family Health – President & Cofounder
I'll introduce the topic again. I think the issue here has a few components. One of them is clearly that there appear to be a lack of robustness, if there's such a word, in the products that were being delivered to people, in that they passed certification, which I'll thank Charlene for explaining this to me, just means that they can demonstrate that they performed a certain functionality. But in reality what we heard from all, I guess, six members of the panel was that the systems took an enormous amount of time to implement and in fact crashed frequently. In many cases the production of this certified requirement just was so inefficient and difficult that it met the requirement by the letter of the law but not by any sort of usability standards. So keeping in mind how difficult I hear the certification process is to begin with, I think we do need to deal with this because we're going to end up with promoting a lot of unhappy people out there. So that's one element. It's like what does it mean to get certified. Is there any standard involved in how the functions that we're calling out get met and how can we enhance that process?

The second thing we heard is just the overwhelmed ... of the vendor community in relationship to supporting existing users. I think how that was reflected in the sense that people are still out selling systems at an enormous rate, as we're being successful in stimulating providers to buy systems, the vendor community is out selling as quickly as they can, but a sense I think from the people that we heard from that support was a continuing issue. So from my perspective that means that certification needs to go beyond test scripts into something else that looks at, as we're talking about patient satisfaction, some element of client satisfaction. Some element of satisfaction with support because otherwise what we continue to do is certify products that are meeting the letter of the certification but not able to be used meaningfully by providers because they're inefficient or because certain functionalities are crashing their system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Comments? It certainly was a problem that was expressed.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'll do a little bit of defensiveness here. Again, I thought there were certainly some issues. I think the overarching theme though was there was a rushed timeline here which made it hard for the vendors to get their software tested, made it hard to get it implemented, everyone was rushing, which caused some of these, whereas, ... slowing down the timeline pretty consistently. There were some positive comments in the testimony about the support the vendors had received pretty much across the board on multiple vendors. Certification, as Neil said, is exactly an assurance to the provider community that the software they purchased will achieve the meaningful use objective, again, but it's dependent on them implementing. So it is not a consumer protection program, that was never the intent in terms of the law, but it's certainly an intent that it will help them achieve meaningful use. There's a lot of work, if you will, to change the current certification process to make it that broader program, so I'm not sure how to recommend, there were a lot of different points that I thought were made in that testimony around this space.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, we're aggressively pushing the timeline in terms of, one, implementing EHRs, and two, having a higher bar for functionality, some of which has to be newly developed for the entire industry. The problem is we have some immature functionality being pushed out, so it seems like we need balance measures of how well did the functionality work. Ideally, it would be nice if you just ran it through this automated testing system and it told you, but I don't think that exists currently. There's some work going on, I think ONC's working with NIST to say is there a way you can test or assess usability of a system, and we would like to have that but I don't know that that exists for EHR at this time. But there is some activity to have reporting on satisfaction, usability, or experience of using the systems. Maybe that has to be made more robust or encouraged because that would be the "balance" measure, just having functionality listed as present or not. I think what we do need to do is have that information get out, one, get out in a fair way, but also give people some fair warning as they make the selections of which vendor's product they would choose and implement.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, I think that concept of the user experience, because that would caveat in not only meeting the functional needs, but also do they feel productive in using the system, and all those types of things. It's a nicer concept to me and it doesn't take six clicks to be able to do this, because it's really the experience, and again you've got advanced users, beginner users, and all that type of thing. That would really start to net out what works and what doesn't work.

Neil Calman – Institute for Family Health – President & Cofounder
One basic measure could be the extent to which people who have the system implement it for some minimal amount of time, whatever it would be, six months or a year, have actually been able to achieve meaningful use. Because I do think it goes beyond just well, we deliver the system and then it's up to the provider to achieve meaningful use. There are vendors that actually guarantee and support their products and support their users to become meaningful users, and I think that we've heard good practices, as you've pointed out, Charlene. So that's one issue that could be looked at.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I wonder if from recommendations from the Policy Committee point of view, whether we could promote the development in the private sector of measures that assess the efficiency and effectiveness of system use. So just like the providers are being judged on their meaningful use of technology of HIT carry on their primary mission in patient care, vendors, who prior to a purchasing need to be assessed on the efficiency and effectiveness or need of the use of their product, the ability of the providers to efficiently and effectively use their product. That's the only balanced module we have and it certainly would be of service to the rest of the provider community as they make these decisions.

Neil Calman – Institute for Family Health – President & Cofounder

I think this is a consumer protection issue. That's what we're putting our money into is protecting consumers so that the people who buy the products can actually achieve the kind of practice innovations that we're promoting. It is a consumer protection issue and we have failed if we're certifying vendors and products that don't help people achieve that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Well, I'm getting a little worried we're going beyond our bounds. So what are my concerns? One is, we don't want to stifle innovation, and maybe the best way to achieve meaningful use is through some new method, and to the degree that we fine-tune exactly how it has to be enacted in the nation, I worry that we'll lose some innovation. Is there some unintended consequence of being too prescriptive on exactly how the thing has to roll out? On the other hand, outcome measures, I think the idea of looking to see who achieved meaningful use and what products they used, that's not our purview to say, but I think that's a great idea, so then other doctors can see who's actually succeeding and then that transparency usually improves competition. So I don't know what it is, but I don't want to come up with a set of rules or something. I think it's stepping beyond what we're supposed to be doing.

Christine Bechtel – National Partnership for Women & Families – VP
I agree, and I'm struggling with the fact that we don't have a lot of time on this call. I think it's a valid issue. We have a Certification and Adoption Workgroup, and I'm wondering if we can ask them to put together a set of recommendations that are designed to promote the kinds of things that Neil's describing but don't rely solely on public policy but also think about what we could encourage the private sector to do as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think, George, in response to your comment, I don't think we're specifying even rules that people have to comply with. I think really it's a consumer assessment, it's a consumer report in a sense of are the vendor products efficient and effective to use. It's that kind of qualitative question we're asking. I think what we're doing, and maybe the Certification Adoption Workgroup is the right recipient of this recommendation, but from the Meaningful Use Workgroup we are suggesting that promoting the use of some kind of assessment of the vendors' products in terms of the ability to do it efficiently and effectively and usefully. So it's pretty general, but I think whoever made the suggestion it may be directed towards the Adoption and Certification Workgroup.

Marty Fattig – Nemaha County Hospital – CEO
I think part of what we're talking about here is actually something I've seen over the years called "competitive advantage." Certain systems do things better than others. Certain systems do things better in certain locations than others do. But it's certainly not a consistent thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is the group comfortable in us making the recommendation that ONC promote some kind of measure of the EHR products that are being used with regard to the efficiency and effectiveness with which providers can use them? It has to be worded better.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, my question would be there is now, and I forget which workgroup has it, Certification and Adoption does have a workgroup that is looking at usability. They were advocating starting to factor in usability already into stage two, but I think that isn't going to happen. So there seems to be an initiative already that's been discussed and is being .... And again, a lot of pushback to try and make it not prescriptive so that you can get the innovation to the table to improve a ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right. That was chaired by, I think, Marc Probst and Larry Wolf.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul, that was the Certification Adoption Workgroup, and they had a hearing on usability.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And then reported out on that, I don't know that it was a recommendation, and I think what this particular group of members on the call are suggesting is not moving towards prescriptive usability measures, really some kind of assessment. It's along the consumer protection line, some kind of assessment so there is a say about the effectiveness of these systems that we're asking people to adopt.

Neil Calman – Institute for Family Health – President & Cofounder
Yes, I think that's a good approach and I think we could go as far as basically calling out that ONC or some other body should be doing an assessment of satisfaction on the part of providers with different systems and making that information public. I think that to speak to the issue of the competitive advantage part, I think there's nothing like public disclosure to put things out on the table. I think a formal mechanism to assess users as to their satisfaction with various products, ease of use and other things, and making that information public should be a function of some official entity. And I think that will drive the market to the places where we're getting the most bang for our incentive dollars.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so I think I'll try to come up with some wording, but we seem to be in favor of ONC making further efforts to promote or encourage development of some kind of balance measures in terms of the effectiveness with which we can use these systems, likely to be done in the private sector, and there are efforts out there.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, that was Charlene. I wanted to caveat there are private sector efforts out there to do this already.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. So we're trying to raise the people's awareness that just MU certification is probably not enough in making your decision about which products to buy. Okay, so if we can move on, let's go back to the agenda item where Christine put together a document suggesting some possible revisions of criteria in conjunction with our movement of that one cell in 2014. Can you –

Christine Bechtel – National Partnership for Women & Families – VP
Sure. We had agreed that if we were giving both vendors an extra year to be able to code the systems and providers an extra year to stay in stage one, at least that first group of providers, that we would take a look at the criteria and see what we might need to evolve and what we wanted to evolve but couldn't quite get there because of mostly technological limitations. That was the lens through which we put together this document. The first three elements are actually just new fields. So it's demographics, and by that we meant the IOM categories, which we should have said here, but that's what we meant, smoking status, and family health history. So you've hopefully got the document ... read it, but those are just simply new fields that build on what we had already agreed we wanted to do.

The second three are areas where we felt like given the extra year, particularly for provider planning and workflow, where we felt like things needed to go farther than they could. So it's not changing the criteria largely, but really kind of evolving the level at which we're asking people to do things, and not by much, but by a little. So that is number one, discharge instructions. Our sense was that we felt like we went backwards here, so we had hospitals actually say to us, "Doing 25 is like a no-brainer. I can pay somebody to do it in a day." That is a direct quote. So what the group intended was to change workflow processes and engage patients in this incredible investment. So we had said, okay, given that there's another year for hospitals to do things, we're suggesting that you actually increase the threshold to a percent, 20%, or you have hard count numbers, if that's what people feel like they have to do, but you actually group them by hospital size. That was the first one.

The second is secure messaging. The same thing, but for secure messaging, since so much really is going to, I think, hinge to secure messaging and that there was actually a lot of agreement about the importance of this criteria and the capability for a system to do this today, going again to a hard count seemed like a step backwards to us. So we're suggesting to go to a threshold, because that is a countable thing.

Then the third piece is the patient contributed data. This is one of those where in our work with the Quality Measures Workgroup as well as this workgroup for Meaningful Use, we had all talked about the desire to see some form of patient contributed data in stage two, but felt like we weren't ready given the timing. But since we have more time, what we suggested here is basically a menu, a really flexible, pretty lightweight menu for providers to say, I'm doing one of these things. It's just an attestation that they're doing one of these things and telling us which one it is. And these are things that we pulled based on what's already in, most of them are already in stage two in some form or fashion, so information reconciliation through secure messaging, family health history, as we're ... codes. So there are some other things that they could do through messaging or portals or whatever, but we just gave a flexible list for people who want to do one of these, that that was how we might get at that.

The rest of the document we actually don't need to talk about because we already took care of it in our first discussion and we will revise according to that. As a summary, the first three are just new fields. The second three are evolutions. These are the only evolutions we're asking for given the extra year of time that folks would have. So we thought we would really try to be reasonable in our approach here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Maybe we can take these in clusters. Cluster one, as you said, are new fields. Let me just put the timing in context. The time required for, these are basically new standards that you're asking for, that takes calendar time and that would still have to be done within the time frame that ONC and CMS are putting together their rule.

Christine Bechtel – National Partnership for Women & Families – VP
No, not ... that new standards are required in all of these, because I don't think they are. Family health history, the letter that we got from the assistant secretary said standards already exist at a default level, major vendors are already implementing them, Epic, Cerner and others, they're open source, they're out there. Now, I'm hoping that ONC has done the homework on this, but all I can go by is what the assistant secretary told us, but they had told us there are in fact detailed standards. So it's not a standards development issue there. I think it probably is, with respect to the IOM demographics, I'm not sure but somebody could check on that and check on smoking status, but I think that there is a standard for that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So if anybody else wants to weigh in. I'm not aware of standards of any ....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We've validated that too, and again, the family history is an implementation of an example family history and even some of our vendors say on family history they collect even better data than that family history. Again, I think as you look at family history there are a lot of concerns about can you collect it or not. That's kind of a slippery slope. Is the ... right? It was recommended that standards be developed. There was a starter set for those fields, but the standards have not been defined. Then, smoking cessation, there's about I think 200 of them out there. So I think signaling that they need to evolve standards in areas is appropriate, but it will be a really steep slope to climb to have those defined and in place, I think, in stage two.

Christine Bechtel – National Partnership for Women & Families – VP
Charlene, let me ask you two questions. One is, it's not a smoking cessation field. It's secondhand smoke.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Secondhand smoke, sorry.

Christine Bechtel – National Partnership for Women & Families – VP
Only. So it's like a yes or a no. Do you know, I thought that there was a standard on that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

What we had understood when we did some research on it, there was probably about 200 variations in that particular area. Again, there's work that's being done in this area because they recognize that it's an issue, but I don't think it's standardized yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene, what did you mean when you said that people aren't sure they can collect family history?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Like how much can you collect about other family members and store that in your database and when do you have to have the permission to store that information, and what if you have sensitive data, that type of thing. So there were concerns, and especially as you start to think about it in useful exchange. Those are some of the issues that were raised.

Christine Bechtel – National Partnership for Women & Families – VP
Let me make a suggestion. What I'm not hearing is debate about the need for these fields. So it may be that what we could do is ask the Standards Committee to tell us with certainty about each of these areas and whether it's realistic for stage two or not. Because if it's not realistic then I think we completely understand that. But I also am hearing not a lot of certainty and I also actually see a lot of conflict between what the assistant secretary for health is saying to us about family health history and not, and feel like since it's another senior political leader who's asking we should probably really do the work. So it may be that what we do is recommend that the Standards Committee tell us the state of play with respect to standards in these areas and whether it's possible for stage two or not. Then let that decision go to ONC and they can decide what they do in the Standards and Interoperability framework from there.

David Lansky – Pacific Business Group on Health – President & CEO
I'd make a stronger argument even that we could ... Policy Committee, say this is a really urgent, critical need that should be accelerated regardless of the current state of the standard. I was looking back at Mike Levitz and other people's speeches in 2005 when they said this was a priority, and now it's six years later and if it's not feasible now that's pretty serious. The old medical clipboard and repeated capture of it has been a senior cabinet level priority for six years. I think we should say it's time to get this done.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, but what's this? We went through an imperfect process and decided what's most important, and that was a several month's long process with the RFC and everything. And now very quickly we're trying to say, okay, these four things, or however you want to number them, because it's hard to say how many fields there are, are the most important things for the nation next.

Christine Bechtel – National Partnership for Women & Families – VP
No, George, that's not what we're saying.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
... we have the disparities, the smoking, the family history, I guess those are the ones, that summarizes it because those are the three items.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, but that's not what we're saying, George. What we said is that we had already, as you note, in the last several months agreed that the IOM category secondhand smoke and family health history were very important. But we also put them aside because we thought that the standards weren't there, the technical capabilities weren't there, and so the direction of the Policy Committee at our last meeting was, okay, now you have an extra year, is there something else you can do. So we simply went back literally through our notes over the last several months and thought, well, these are three that were put aside for technical reasons largely only, so let's see if we can really move them forward from a technical perspective. So we're not trying to establish national priorities here. We had already agreed that these were important.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Christine, let me just reemphasize they weren't technical reasons, they were lack of standards. That's not a simply turn the switch on and off, and standards take a finite amount of time to develop. The time we gave to that early entrant group has nothing to do with the time table for CMS to develop its NPRM and final rule. So that hasn't changed. Over the next six months they will have an NPRM developed and the standards, if they do not exist, we won't have enough time to put that into place. We certainly can take your suggestion. We've already decided these are all we want to have happen by stage three, so that signal is there. Your additional suggestion that can we ask the HIT Standards Committee, can we advance any of these or all of these to stage two; that seems reasonable.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The discussions were more complicated than this. Secondhand smoke, I remember the discussion came down to well, firsthand smoke was probably important for every subspecialist. Secondhand smoke was probably more important for the PCP, the internists, less so for certain subspecialists because it's not a risk factor that affects their field, so I'm just saying that the discussions were a little more complex than that. If we're going to mandate that every EP in the country ask about secondhand smoke because now we have the delay of that group by a year, I have to think about all the subspecialists who would have to record that or whether all the disparity is relevant for everybody. I guess the family history is roughly relevant. It depends on how much is in there. Maybe we solve it with the other method, which was to come up with specialist tracks.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's a different way to solve it. I think certainly for a primary care provider you're going to want to know about secondhand smoke, I'm not doubting that.

Christine Bechtel – National Partnership for Women & Families – VP
George, I think you're right. That is a problem that multiple criteria, that we've already agreed on separate from, not just these, and recording demographics is a great example because the argument that you just said about subspecialists collecting disparities data, race, ethnicity, language, and gender, that's already part of stage one and it's mandatory. All we're asking is a refinement on the IOM fields to get more granular with that data. So I think that's a problem that exists regardless, so if we're absolutely out of time I think if we can get the Standards Committee to tell us what's the state of play here and is it reasonable to accelerate them for stage two, then that tells us what we need to do next.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And clarity on the family history, there's a lot of data elements that constitute a family history, so it's more than one field.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, do you want to go to the next –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so the latest suggestion we had was target these for stage three and ask the Standards Committee if any of these are eligible to be moved up to stage two, if the standards are there and mature.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Judy Murphy – Aurora Health Care – Vice President of Applications
Just a question about number one, do we need to add clarity about what the new fields are that we're recommending?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, sorry, Judy, we should have said, it's the Institute of Medicine fields that we recommended.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes, before we forward it out we should just add that.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Then the second cluster has to do with a lot of the countable numbers, maybe we should take these one at a time. But maybe there's a philosophy just to recapitulate from the last discussion, there's a sense that having a number, a finite countable number helps us with the denominator problem. But also it's with the belief that people are not likely to turn off useful functionality or to stop using it after they've achieved that finite countable number. You gave an example, I don't know that we can design something for people who want to ... the system. To me that seems like the exception. Why would you hire somebody to go to 25 discharge summaries and then turn it off?

Christine Bechtel – National Partnership for Women & Families – VP
Because –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's not where you're going to need to be.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, but this has nothing to do with a year delay, though, this item, engaging patients ..., like whether we go 25 or 250, this is about redoing our objectives and measures, not about the fact that we have an extra year therefore they can do 250 instead of 25. So it's kind of opening up the discussion on all our objectives and measures and seeing whether we should go back through them all again.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, we did not raise every single one. You absolutely are correct that we went through every single one because that was what we talked about in the Policy Committee –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I could ... too and find a bunch of stuff that I think should be changed back in my direction. I don't know. As Paul said, the intent of the 25, the alternative was 1 and they said, okay, let's make it 25. It wasn't that we were coming down from 1,000 and we were going up from 1.

Christine Bechtel – National Partnership for Women & Families – VP
No, we were coming back –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
.... someone to –

Christine Bechtel – National Partnership for Women & Families – VP
....

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I understand your point, and maybe they do have to attest that it's done through the system and not manually, or something like that. In other words, is there a way to say you can't cheat? If they can cheat for 25 maybe they can cheat for 100 also. We'll always be in that problem, and so maybe there's

something we can stipulate that says the 25 has to be done through the normal working of the system, not having a person circumventing the system. I don't know how to phrase that, but that's your intent is not to have them circumvent it, I think.

W
The intent is to have the care process actually change as a result of using the technology. And the question is whether a flat count of 25 gets us there, and I think that that depends a lot on the size of the provider. As Christine said, 25 in some places is very easily achieved in a day or the morning even, so –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, it's actually difficult to achieve. It's probably going to take them a year to get the stuff installed and running and interfaced, and that's really what the 25 ... for large and the small. Then we're assuming once they have this thing running they're going to use it because it's useful, and if everyone doesn't use it then maybe we've made a mistake in including the objectives.

Christine Bechtel – National Partnership for Women & Families – VP
So actually I think that's where we're differing, which is we assume that that's actually not really the case. And we heard this in the hearing, which is that when it comes to a patient and some of the patient and family engagement criteria almost to a person ... or two weeks ago what the providers told us was this was on our list to do forever. But we never would have done it without being forced to do it because it's hard and because it doesn't necessarily translate, at least directly in their minds, to performance on other requirements like quality measures that they're thinking about. Although I would suggest that's not really thinking big picture, but nonetheless, so we really, and have said all along that going to a hard count number to give people flexibility wasn't probably the best approach from our perspective. Because I think the number is so low that the assumption that people will keep doing it because they find it useful, I think the number's too low to even give them a sense of whether it's useful, number one. And number two, we continue to hear real pushback about the utility and value of some of these things that I think we believe still and agree are really valuable and important.

So getting people to just do something 25 times isn't sufficient. So when we looked back and said, gee, we have an extra year to do implementation and workflow planning and engagement, the hard count numbers were the things that really stuck out. So that's why we're suggesting that a percent is actually more meaningful or something that gets you doing it more often if you're a larger facility.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Christine, from a process point of view, I think I'd have to agree with George that we're revisiting the same discussion.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, we are.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we decided that some countable number was, one, less burdensome for people to show that they met the criteria, but two, I think the majority of folks felt like there wasn't a really good reason, other than that we were completely wrong and this is bad functionality, for people to either turn off or stop doing something. As George pointed out, the hard work actually is to build the functionality and train people to do that workflow.

Christine Bechtel – National Partnership for Women & Families – VP
Right, but if you only have to do it 25 times, why would you make an investment in training people and building it into your workflow given all of the other criteria. When you can just get somebody to do it one time in one day or in one week or in one month and be done with it and go on to the next amount of training. Let me just say one other thing, which is my understanding, and what I know at least I was clear about with this whole timing option thing was that if we were going to give people extra time it wasn't okay not to make any changes whatsoever in either stage one or stage two. That doesn't make sense to me. So that is the origin of this discussion. It's not about reopening, well, it is in a way opening everything

back up and looking at it, I mean, we were obviously judicious in what we did. But it was because, and I know I was clear about this both in our workgroup meeting and at the Policy Committee meeting. That if we're giving people lots of extra time to do the same thing, that we ought to make sure that stage two is actually more meaningful and the hard count numbers to patients on the patient and family engagement things are not particularly meaningful.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, another thing that we learned between our original discussions and today's discussion is from that specialist hearing, where we heard, and I'm quoting from Weill Cornell, a physician organization, they said, "It's challenging to cram more and more requirements into brief patient encounters," and that is directly related to Christine's point about changing workflows. The idea, and I know from having done this work that what we're not going to solve is the fact that providers will get a checklist, which is the criteria we've come up with that they're trying to meet. So with a lot of criteria you're going to meet the criteria the easiest way possible, and if we've got a low number like 25 count of certain criteria, then that is not enough to incentivize actual workflow changes. We know that. We've heard it word for word from them because they're trying to cram more and more into brief patient encounters. The point of this is to change workflows using health IT such that they're not providing care in the exact same way that they're trying to do it now, and the only way to get them to do that is to give them a target that simply makes the status quo impossible, and 25 does not do that.

David Lansky – Pacific Business Group on Health – President & CEO
I think we have to do something here to make sure there's a signal to the industry that by 2014 we're talking about ... continuing to receive stage two payment, this has to be a routine part of what you're doing. I am concerned that a number as low as 25 will not send that signal to the vast majority of providers out there. It will be like a token thing, you try to find a last minute way on December 2014 to get to satisfy.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Previously we talked about just attesting to being able to do it, like MEDREC, similar –

David Lansky – Pacific Business Group on Health – President & CEO
It seems like such a simple thing. It's part of the ACO requirements. This functionality of patient communication of information I think we've said all along is a core, one of our five or four top priorities, and this is, we're talking 2014 here, the end of stage two you have to be able to do something –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But the complicated thing here is that you're giving it electronically to the patient while they're standing in front of you as they're walking out the door, as opposed to view and download, where they're home and where they have some time to get to their computer. So our assumption is almost no one wants an electronic version of the discharge instructions. They almost all are going to want it on paper. That's how this discussion went in this direction, we wanted the ability to do it but we couldn't imagine anyone who would actually want an electronic version of the discharge instructions themselves.

Judy Murphy – Aurora Health Care – Vice President of Applications
I'll just echo that comment. That is playing itself out over and over with every single discharge we have. Nobody wants it electronically. They like the summary of care electronically, but they do not want the discharge instructions, because they want it in front of them with their prescriptions and all the stuff that they're walking out with.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We did set a percent threshold on view and download, because that one, we saw that as more feasible. I think part of the reason we ended up here was worrying about that issue. Also, just for the record, we picked this timing option because it didn't give a lot of extra time to most EPs. Most people see the same thing they would have seen anyway. It's mainly the vendors we help because they get an extra year to implement because they don't have to have it ready by 2013 because most people will be using it in 2014. It's the small group who are actually affected for those 12 months, the vast majority of providers

don't actually see extra time in the timing option that we're, well, we're giving a set of options, but the one we're recommending the most only affects a small number of providers.

Christine Bechtel – National Partnership for Women & Families – VP
One way to deal with the discharge instructions would be to actually not have it be a separate criteria and have it be connected to the summary and care plan that we already agreed upon.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, that's true. That's another way to look at it.

Christine Bechtel – National Partnership for Women & Families – VP
And I'm fine with that, but I want to be sure that people understand it means that that needs to be a core requirement.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, so that would be a way around it would be to include the discharge instructions electronically in the summary and have that ... just follow the 10% or whatever we put down in our request. That might not be bad.

Christine Bechtel – National Partnership for Women & Families – VP
I'm fine with that. I think that –

David Lansky – Pacific Business Group on Health – President & CEO
Yes, it makes sense to me.

Judy Murphy – Aurora Health Care – Vice President of Applications
I could support that as well.

Deven McGraw – Center for Democracy & Technology – Director
Likewise.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We've got a ... agreement, so we have to get to the public comments.

Christine Bechtel – National Partnership for Women & Families – VP
So, Paul –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Secure messaging, I think these other two are also, it's the same argument about do we make sure that it exists, it's been built and people know how to use it. For example, I don't know that they're going to, after they get 25 messages, turn off secure messaging. Why would they do that?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
If they have it integrated into their workflow in a way that allows them to sufficiently manage it, sure, they will. They do it all the time.

Deven McGraw – Center for Democracy & Technology – Director
I think some of this is about arguing about thresholds, not about value. And maybe the way to work this is to set a very clear, high goal for stage three, but a lower threshold for stage two so we at least know that it's getting started. Some of this is about arguing about measurement versus the value of getting it done, and we're measuring a lot here. I recognize that it's attestation, but it's attestation under penalty of perjury and we have to remember that, but at the same time not undervalue the patient engagement criteria. So if we're going to deal with the issue of measurement, we need to deal with it across the board and not just here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Actually, as you bring that up, a quality measure can be one way to assess this. Right now we're just talking about how do we make sure it gets built and implemented and put into use, but we can measure the effects of this on the QM side.

Deven McGraw – Center for Democracy & Technology – Director
I can't say that that's an appropriate tradeoff, because I don't know where the measures are that would measure this particular aspect of it, but that's –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It could be percent of patients who use it. That certainly can be.

Deven McGraw – Center for Democracy & Technology – Director
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In fact we use that here.

Deven McGraw – Center for Democracy & Technology – Director
I'm afraid I'm going to have to get off –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I think we all have to.

Deven McGraw – Center for Democracy & Technology – Director
... because I've got another call at noon.

Judy Murphy – Aurora Health Care – Vice President of Applications
Paul, I'm just curious what we're going to do about that behavioral health stuff that you sent –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Judy sent that out as FYI.

Judy Murphy – Aurora Health Care – Vice President of Applications
Just FYI, thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Most of those are quality measures.

Judy Murphy – Aurora Health Care – Vice President of Applications
Thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, if it's all right with people could we open up for public comment?

Judy Sparrow – Office of the National Coordinator – Executive Director
Sure. Operator, can you see if anybody wishes to make a comment at this time?

Operator
You have public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
All right, great, if that person can please identify themselves.

Julie Cantor-Weinberg – College of American Pathologists – Dir., Public Health & Scientific Affairs

This is Julie Cantor-Weinberg with the College of American Pathologists. First, I want to thank the workgroup for allowing us to testify at the specialist hearing a few weeks back. I wanted to clarify a couple of issues that came up today.

It was the Continuing Education Act of 2010 that modified the definition of "hospital-based" by taking out services provided in an ambulatory setting that made most of our members eligible for incentives and penalties. I think some of the core measures, even in stage one that you're thinking of expanding on for stage two, simply don't work for pathologists. Even basic things like demographic data, we don't always know things like preferred language, but it's not as simple as cleaving out physicians that don't have patient contacts. Some of our members do when they do fine needle aspirations or sit down occasionally with patients to explain biopsy or other reports. I'm a bit concerned about requiring some kind of structured reporting mechanisms, particularly in the anatomic pathology side we already have recognized by the American College of Surgeons cancer reports that are in fact structured, so putting another requirement on top of that may be problematic and our reports are in fact required for ... accreditation of cancer centers. Measures on patient engagement can be hard when there's a requirement to inform the patients because in many cases that conflicts with state law on CLIA and the requirement that data only goes to the authorized person.

Lastly, I would urge caution as care teams are defined that you don't exclude pathologists because you'll end up with some of the same problems we discussed in the hearing, where pathologists can't get access to the full patient record and it precludes their ability to provide optimal care. With that, I'll sign off. Thank you very much.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Julie. Do we have any other comments?

Operator
Yes, we do.

Jan Medden – University of Pittsburgh Medical Center Health Plan – Regional Extension Center Consultant
Hi, this is Jan Medden from University of Pittsburgh Medical Center Health Plan, and I'm a regional extension center consultant, so I'm out in physician offices all the time. I just wanted to really echo something that one person said about the amount of information you have a physician gather. I have a great appreciation for how complex it is to be a physician these days and how many requirements there are. So I just wanted to echo and encourage you that whenever you decide that physicians need to gather certain data, that it be absolutely crucial public health data or data to use for outcomes, because as time goes on and things get tighter and physician appointments get shorter, it's just becoming more and more difficult for them. So I'm just speaking as a physician advocate.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Jan. Anybody else?

Operator
There are no more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. I'll turn it back to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you, everyone. I think we've accomplished a lot with this two hours. We'll reflect that in the material we present back to the full Policy Committee, and I know that we have a couple of things we're going to ask them to help us sort out. Thanks so much for putting in the time, and we will see you next week in D.C.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Paul. Bye-bye.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Bye-bye.

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Thank you, Paul.

Public Comment Received During the Meeting

1. Say for example...scope of services is changing...the physician shortage is now considered “unscale-able" so a discussion about nurse practitioners and PA's could be a very good idea.

3. There are several considerations here that could be worth discussion.

4. On the definition of the care team, it would be a good idea to list the patients support group (which could include family members) to be sure the information is disseminated.

5. The shift appears to be exclusive rather than inclusive of building a representation of the clinical model. The intent of the law.

6. I am encouraging the inclusions of other outliers for a more complete discussion

7. What about the pharmacists?

8. Pathologists occasionally see patients, for example to perform fine needle aspirations.